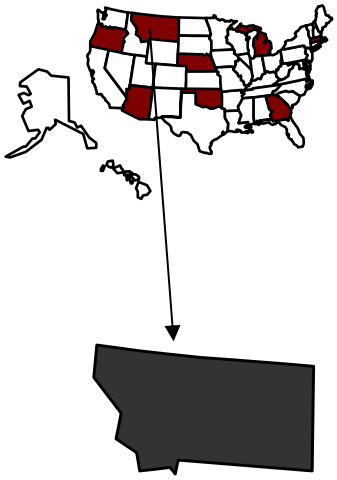

# THE HEALTH CARE WORKFORCE IN EIGHT STATES: EDUCATION, PRACTICE AND POLICY

Spring 2004

# MONTANA

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# The Health Care Workforce in Eight States: Education, Practice and Policy

# PROJECT DESCRIPTION

Historically, both federal and state governments have had a role in developing policy to shape the health care workforce. The need for government involvement in this area persists as the private market typically fails to distribute the health workforce to medically underserved and uninsured areas, provide adequate information and analysis on the nature of the workforce, improve the racial and ethnic cultural diversity and cultural competence of the workforce, promote adequate dental health of children, and assess the quality of education and practice.

It is widely agreed that the greatest opportunities for influencing the various environments affecting the health workforce lie within state governments. States are the key actors in shaping these environments, as they are responsible for:

- financing and governing health professions education;
- licensing and regulating health professions practice and private health insurance;
- purchasing services and paying providers under the Medicaid program; and
- designing a variety of subsidy and regulatory programs providing incentives for health professionals to choose certain specialties and practice locations.

Key decision-makers in workforce policy within states and the federal government are eager to learn from each other. This initiative to compile in-depth assessments of the health workforce in 8 states is an important means of insuring that states and the federal government are able to effectively share information on various state workforce data, issues, influences and policies.

Products of this study include individual health workforce assessments for each of the eight states and a single assessment that compares various data and influences across the eight states. In general, each state assessment provides the following:

1) A summary of health workforce data, available resources and a description of the extent the state invests in collecting workforce data. [Part of this information has been provided by the Bureau of Health Professions];
2) A description of various issues and influences affecting the health workforce, including the state's legislative and regulatory history and its current programs, financing and policies affecting health professions education, service placement and reimbursement, planning and monitoring, and licensure/regulation;
3) An assessment of the state's internal capacity and existing strategies for addressing the above workforce issues and influences; and
4) An analysis of the policy implications of the state's current workforce data, issues, capacity and strategies.

The development of the project's data assimilation strategy, content and structure was guided by an expert advisory panel. Members of the advisory panel included both experts in state workforce policy (i.e., workforce planners, researchers and educators) and, more broadly, influential state health policymakers (i.e., state legislative staff, health department officials). The advisory panel has helped to ensure the workforce assessments have an appropriate content and effective format for dissemination and use by both state policymakers and workforce experts/officials.

# STUDY METHODOLOGY

**Study Purpose and Audience**

Key decision-makers in workforce policy within states and the federal government are eager to learn from each other. Because states increasingly are being looked to by the federal government and others as proving grounds for successful health care reform initiatives, new and dynamic mechanisms for sharing innovative and effective state workforce strategies between states and with the federal government must be implemented in a more frequent and far reaching manner. This initiative to compile comprehensive capacity assessments of the health workforce in 8 states is an important means of insuring that states and the federal government are able to effectively share information on various state workforce data, issues and influences.

Each state workforce assessment report is not intended to be voluminous; rather, information is presented in a concise, easy-to-read format that is clearly applicable and easily digestible by busy state policymakers as well as by workforce planners, researchers, educators and regulators.

**Selection of States**

NCSL, with input from HRSA staff, developed a methodology for identifying and selecting 8 states to assess their health workforce capacity. The methodology included, but was not limited to, using the following criteria:

a. States with limited as well as substantial involvement in one or more of the following areas: statewide health workforce planning, monitoring, policymaking and research;
b. States with presence of unique or especially challenging health workforce concerns or issues requiring policy attention;
c. States with little involvement in assessing health workforce capacity despite the presence of unique or especially challenging health workforce concerns or issues requiring policy attention;
d. Distribution of states across Department of Health and Human Services regions;
e. States with Bureau of Health Professions (BHPr) - supported centers for health workforce research and distribution studies;
f. States with primarily urban and primarily rural health workforce requirements; and
g. States in attendance at BHPr workforce planning workshops or states that generally have interest in workforce modeling.

**Collection of Data**

NCSL used various means of collecting information for this study. Methods exercised included:

a. Phone and mail interviews with state higher education, professions regulation, and recruitment/retention program officials;
b. Custom data tabulations by national professional trade associations and others (i.e., Quality Resource Systems, Inc.; Johns Hopkins University School of Public Health) with access to national data bases;
c. Tabulations of data from the most recent edition of federal and state government databases (e.g., National Health Service Corps field strength);
d. Comments and guidance from members of the study's expert advisory panel.
e. Site visit interviews with various officials in the eight profile states;
f. Personal phone conversations with other various state and federal government officials; and
g. Most recently available secondary data sources from printed and online reports, journal articles, etc.

# STATE SUMMARY

Montana is very rural, largely frontier, state with a small minority population. The state's proportion of residents without health insurance is above the national average. This is partly attributable to Montana's predominant number of small business who say they cannot afford to offer such coverage to their employees. Of equal concern is the persistent lack of geographical access to health care professionals. The proportion of the state's population residing in primary care health professional shortage areas (HPSAs) exceed the national average; the percentage living in dental HPSAs is more than double the national proportion. Montana's overall per capita supply of physicians and nurses is also below national ratios. The state's number of pharmacists and dentists per capita mirrors or exceeds nationwide figures.

Efforts by the state to address health workforce shortages have been piecemeal. Montana enjoys having a ratio of National Health Service Corps (NHSC) professionals per HPSA population that is nearly four times the national ratio. State officials openly state that Montana relies heavily on the NHSC program to address its physician shortages. The Montana Rural Physician Incentive Program, a loan repayment initiative created in 1991 to encourage primary care physicians to practice in rural medically underserved areas of the state, and the Montana Family Practice Residency, established in the late 1990s to accomplish a similar objective, are two state programs also viewed as important in addressing workforce needs. Also seen by state officials as somewhat effective is Montana's tax credit for health professionals practicing in rural areas of the state.

Growing concern with mounting shortages of health care workers prompted Montana's governor in 2001 to appoint a Blue Ribbon Task Force on Health Care Workforce Shortages to assess the extent of the problem and develop recommendations and strategies to effectively address the issue. A 2002 report offered various recommendations to improve educational opportunities, the health care work environment, worker reimbursement and compensation, and workforce data collection and analysis. Since the issuance of the report, there appears to be no comprehensive support to address the report's findings and recommendations. The Montana Area Health Education Center (AHEC), Department of Public Health and Human Services' Primary Care Office, Montana Department of Commerce, and others routinely track certain supply trends associated with the state's health care workforce.

A large proportion of active physicians work under *locum tenens* arrangements and do not have a regular practice in one or more locations. The state relies to a significant extent on physician assistants and nurse practitioners to deliver primary care in many locations unable to attract a physician.

A growing consensus that Montana faces a nursing shortage is, like elsewhere, associated with an insufficient capacity of nurse training programs to educate more nurses. There is greater concern with reports that at least 60 percent of newly trained nurses in Montana leave the state upon graduation due to perceptions that Montana lacks attractive or fulfilling work environments for nurses burdened by loans and other issues.

Montana has no dental school and just one dental hygiene training program which recently opened. According to a 2003 survey of the state's dentists, the dentist population in Montana, like elsewhere, is rapidly aging, and there are growing concerns that their supply are not being adequately replenished. The new dental hygiene program, which in essence replaced the state's one school that closed in 1989, is challenged to address the current demand by dentists for hygienists. Many hygienists are recruited to dentist practices from outside Montana.

# I. WORKFORCE SUPPLY AND DEMAND

Arguably, it is most important initially to understand the marketplace for a state's health care workforce. How many health professionals are in practice statewide and in medically underserved communities? What are the demographics of the population served? How is health care organized and paid for in the state? This section attempts to answer some of these questions by presenting state-level data collected from various sources.

**Table I-a.**

| POPULATION | | MT | U.S. |
|---|---|---|---|
| Total Population (2001) | | **904,433** | 284,796,887 |
| Sex (2000) | % Female | **50.2** | 50.9 |
| | % Male | **49.8** | 49.1 |
| Age (2000) | % less than 18 | **25.5** | 25.7 |
| | % 18-64 | **61.1** | 61.9 |
| | % 65 or over | **13.4** | 12.4 |
| % Minority/Ethnic (2002) | | **8.9** | 30.9 |
| % Metropolitan (2002) | | **23.2** | 81.3 |

* As defined by the U.S. Office of Management and Budget

*Sources*: U.S. Census Bureau, AARP.

**Only twenty-three percent of Montana residents live in metropolitan areas.**

**Table I-b.**

| PROFESSION UTILIZATION | MT | U.S. |
|---|---|---|
| % Adults who Reported Having Routine Physical Exam Within Past Two Years (1997) | **78.0** | 83.2 (Median) |
| Average # of Retail Prescription Drugs per Resident (2002) | **9.8** | 10.6 |
| % Adults who Made Dental Visit in Preceding Year by Annual Family Income (1999): | | |
| Less than $15,000 | **53** | |
| $15,000 - $34,999 | **63** | |
| $ 35,000 or more | **75** | |

*Sources*: CDC, AARP, GAO.

**Seventy-eight percent of Montana adults reported having a routine physical exam within the past two years.**

**Table I-c.**

| ACCESS TO CARE | | MT | U.S. |
|---|---|---|---|
| % Non-elderly (under age 65) Without Health Insurance | 2000-2001 | **18** | 17 |
| | 1999-2000 | **21** | 16 |
| % Children Without Health Insurance | 2000-2001 | **14** | 12 |
| | 1999-2000 | **18** | 12 |
| % Not Obtaining Health Care Due to Cost (2000) | | **10.8** | 9.9 |
| % Living in Primary Care HPSA (2003) | | **27.8** | 21.3 |
| # Practitioners Needed to Remove Primary Care HPSA Designation (2003) | | **34** | -- |
| % Living in Dental HPSA (2003) | | **36.5** | 14.7 |
| # Practitioners Needed to Remove Dental HPSA Designation (2003) | | **43** | -- |

HPSA = Health Professional Shortage Area

*Sources*: KFF, AARP, BPHC-DSD.

**Over thirty-six percent of Montana residents live in dental HPSAs and more than one-quarter of Montana residents live in primary care HPSAs.**

**Table I-d.**

| PROFESSIONS SUPPLY | | | | |
|---|---|---|---|---|
| Profession | | # Active Practitioners | # Active Practitioners per 100,000 Population | |
| | | | **MT** | **U.S.** |
| Physicians (1998) | | **1,594** | **181.2** | 198 |
| Physician Assistants (1999) | | **131** | **14.8** | 10.4 |
| Nurses | RNs (2000) | **9,299** | **812** | 782 |
| | LPNs (1998) | **2,360** | **268.3** | 249.3 |
| | CNMs (2000) | **24** | **2.5** | 2.1 |
| | NPs (1998) | **252** | **28.7** | 26.3 |
| | CRNAs (1997) | **61** | **6.9** | 8.6 |
| Pharmacists (1998) | | **640** | **72.8** | 65.9 |
| Dentists (1998) | | **422** | **48.0** | 48.4 |
| Dental Hygienists (1998) | | **490** | **55.7** | 52.1 |
| % Physicians Practicing Primary Care | | | **32.0** (30.0 U.S.) | |
| % Registered Nurses Employed in Nursing | | | **78.8** (81.7 U.S.) | |
| % of MDs Who Are International Medical Graduates (IMGs) | | | **4.0** (24.0 U.S.) | |

RN= Registered Nurse, LPN= Licensed Practical Nurse, CNM= Certified Nurse Midwife, NP= Nurse Practitioner
CRNA= Certified Registered Nurse Anesthetist

*Source*: HRSA-BHPr.

**Only four percent of physicians in Montana are international medical graduates.**

**Table I-e.**

| NATIONAL HEALTH SERVICE CORPS (NHSC) FIELD STRENGTH | | | |
|---|---|---|---|
| Total Field Strength (FY 2003)<br>* Includes mental/behavioral health officials | % in Urban Areas | % in Rural Areas | # Per 10,000 Population Living in HPSAs |
| **49** | **16** | **84** | **1.95** (0.49 U.S.) |

| *Field Strength by Profession* | |
|---|---|
| Physicians | **18** |
| Nurses | **4** |
| Physician Assistants | **7** |
| Dentists/Hygienists | **4** |

HPSA= Health Professional Shortage Area

*Source*: BPHC-NHSC.

**Montana has nearly four times as many National Health Service Corps professionals per 10,000 population as the U.S. as a whole.**

**Table I-f.**

| MANAGED CARE | | | |
|---|---|---|---|
| Penetration Rate of Commercial and Medicaid HMOs (as % of total population), 2000 | | MT | U.S. |
| | | **8.1** | **28.1** |
| Profession | MCOs required by state to include profession on their provider panel* | Profession allowed by state to serve as primary care provider in MCOs | Profession allowed by state to coordinate primary care as part of a standing referral |
| Physicians | **No** | **Yes** | **No** |
| Nurses | **No** | **No** | **No** |
| Pharmacies | **No** | **No** | **No** |
| Dentists | **No** | **No** | **No** |
| State requires certain individuals enrolled in MCOs to have direct access to certain specialty (OB/GYN, etc.) providers. | | | **Yes** |
| State requires certain individuals enrolled in MCOs to receive a standing referral to a specialist (OB/GYN, etc.). | | | **No** |

MCOs = Managed Care Organizations HMOs = Health Maintenance Organizations OB/GYN = Obstetrician/Gynecologist
* This requirement does not preclude MCOs from including additional professions on their provider panels.

*Sources*: HPTS, AARP.

## Only eight percent of Montana residents receive their health care from an HMO.

**Table I-g.**

| REIMBURSEMENT OF SERVICES | | | | | |
|---|---|---|---|---|---|
| | Profession | % Active Practitioners Enrolled | % Enrolled Receiving Annual Payments Greater Than $10,000[1] | Increase of 10% or More in Overall Payment Rates 1998-2003 | Bonus or Special Payment Rate for Practice in Rural or Medically Underserved Area |
| **Medicaid** | Physicians | * | **18.0** | **No** | **No** |
| | NPs | **27** | **9.2** | **No** | **No** |
| | Dentists | **78** | **32.5** | **Yes** | **No** |
| | # of Enrolled Pharmacies | | | | **460** |
| | % Change in Physician Fees (All Services), 1993-1998 | | | | **N/A** |
| | Recent State-Mandated Payment Increases | | | | **Yes** (for dentists) |
| **Medicare** | # Active Practitioners Enrolled (2000) | | | | **1,433** |
| | % Practitioners who Accept Fee as Full Payment (2003) | | | | **90.9** |

[1] Generally seen as an indicator of significant participation in the Medicaid program.
[2] Denominator number from HRSA State Health Workforce Profile, December 2000.
* Numerator data for physicians and nurse practitioners from state Medicaid agencies were unusable: many professionals were apparently double-counted, perhaps due to varying participation in different health plans.

N/A- Data was not available

*Sources*: State Medicaid programs, Norton and Zuckerman "Trends", HPTS, AARP.

**Only eighteen percent of physicians in Montana receive Medicaid payments of greater than $10,000 annually. Over thirty percent of dentists receive Medicaid payments of more than $10,000 annually.**

# II. HEALTH PROFESSIONS EDUCATION

State efforts to help ensure an adequate supply of health professionals can be understood in part by examining data on the state's health professions education programs–counts of recent students and graduates, amounts of state resources invested in education, and other factors. State officials can gauge how well these providers reflect the state's population by also examining how many students and graduates are state residents or minorities. Knowing to what extent states are also investing in primary care education and how many medical school graduates remain in-state to complete residencies in family medicine is also important.

**Table II-a.**

| UNDERGRADUATE MEDICAL EDUCATION | | | |
|---|---|---|---|
| # of Medical Schools *(Allopathic and Osteopathic)* | **0** | Public Schools | **0** |
| | | Private Schools | **0** |
| | | Osteopathic Schools | **0** |
| # of Medical Students *(Allopathic and Osteopathic)* | 1998-1999 | **0** | |
| | 2000-2001 | **0** | |
| # Medical Students per 100,000 Population[1] | 1998-1999 | **0** | |
| | 2000-2001 | **0** | |
| % Newly Entering Students (*Allopathic)* who are State Residents, 2002-2003 | | **N/A*** | |
| Requirement for Students in Some/All Medical Schools to Complete a *Primary Care Clerkship* | By the State | **N/A*** | |
| | By Majority of Schools | **N/A*** | |
| # of Medical School Graduates *(Allopathic and Osteopathic)* | 1998 | **0** | |
| | 2001 | **0** | |
| # Medical School Graduates per 100,000 Population[1] | 1998 | **0** | |
| | 2001 | **0** | |
| % Graduates *(Allopathic)* who are Underrepresented Minorities, 1994-1998 | | **N/A*** | |
| % 1987-1993 Medical School Graduates *(Allopathic)* Entering Generalist Specialties | | **N/A*** | |
| State Appropriations to Medical Schools *(Allopathic and Osteopathic)*, 2000-2001 | Total | **0** | |
| | Per Student | **0** | |

[1] Denominator number is state population from 2000 U.S. Census.

*Sources*: AAMC, AAMC Institutional Goals Ranking Report, AACOM, Barzansky et al. "Educational Programs", State higher education coordinating boards.

**Montana does not have an allopathic or osteopathic medical school.**

**Table II-b.**

| GRADUATE MEDICAL EDUCATION (GME) | | |
|---|---|---|
| # of Residency Programs *(Allopathic and Osteopathic)*, 2002-2003[1] | | **2** |
| # of Physician Residents *(Allopathic and Osteopathic)*, 2002-2003[1] | | **N/A** |
| # Residents Per 100,000 Population, 2002-2003 | | **N/A** |
| % Allopathic Residents from In-State Medical School, 2000-2001 | | **0.0** |
| % Residents who are International[2] Medical Graduates, 2000-2001 | | **5.0** |
| Requirement to Offer Some or All Residents a *Rural Rotation* | By the State | **No** |
| | By Most Primary Care Residencies | **Yes** |
| *Medicaid* Payments for Graduate Medical Education, 2002[3] | | **$0.12** |
| | Payments as % of Total Medicaid Hospital Expenditures | **1.0** (8.0 U.S.) |
| | Payments Made Directly to Teaching Programs Under Capitated Managed Care | **No** |
| | Payments Linked to State Workforce Goals/ Goals of Improved Accountability | **No** |
| *Medicare* Payments for Graduate Medical Education, 1998[3] | | **$1.9 million** |

[1] Includes estimated number of osteopathic residencies/residents not accredited by the Accreditation Council for Graduate Medical Education.
[2] Does not include residents from Canada.
[3] Explicit payments for both direct and indirect GME cost.
N/A = Data was not available

*Sources*: AMA, AMA State-level Data, AACOM, State higher education coordinating boards, Henderson "Funding", Oliver et al. "State Variations."

## Five percent of residents in Montana are international medical graduates.

**Table II-c.**

| FAMILY MEDICINE RESIDENCY TRAINING | | | |
|---|---|---|---|
| # of Residency Programs, 2001-2002 | **2** | # Residencies Located in Inner City | **1** |
| | | # Residencies Offering Rural Fellowships or Training Tracks | **0** |
| # of Family Medicine Residents, 2001-2002 | | | **N/A** |
| # Family Medicine Residents per 100,000 Population, 2001-2002[1] | | | **N/A** |
| % Graduates *(from state's Allopathic and Osteopathic medical schools)* who were First Year Residents in Family Medicine, 1995-2001 | | | **N/A*** |
| % Graduates *(from state's Allopathic medical schools)* Choosing a Family Medicine Residency Program Who Entered an In-State Family Medicine Residency, 1995-2001 | | | **N/A*** |

[1] Denominator number is state population from 2000 U.S. Census.

N/A = Data was not available

N/A*= Data was not applicable

*Sources*: AAFP, AAFP State Legislation, Kahn et al., Pugno et al. and Schmittling et al. "Entry of U.S. Medical School Graduates".

## Montana has two residency programs for family medicine.

**Table II-d.**

| NURSING EDUCATION | | | | |
|---|---|---|---|---|
| # of Nursing Schools | **5** | Public Schools | | **3** |
| | | Private Schools | | **2** |
| # of Nursing Students[1] | **889** | # Associate Degree, 2001-2002 | | **101** |
| | | # Baccalaureate Degree | 2001-2002 | **636** |
| | | | 2002-2003 | **767** |
| | | # Masters Degree | 2001-2002 | **19** |
| | | | 2002-2003 | **21** |
| | | # Doctoral Degree | 2001-2002 | **0** |
| | | | 2002-2003 | **0** |
| | # Per 100,000 population[2] | | | **98.3** |
| # of Nursing School Graduates[1] | **180** | # Associate Degree, 2002 | | **39** |
| | | # Baccalaureate Degree | 2001 | **130** |
| | | | 2002 | **133** |
| | | # Masters Degree | 2001 | **10** |
| | | | 2002 | **8** |
| | | # Doctoral Degree | 2001 | **0** |
| | | | 2002 | **0** |
| | # Per 100,000 population[2] | | | **19.9** |

[1] Annual figure for Associate, Baccalaureate, Masters and Doctoral students/graduates for most recent years available.

[2] Denominator number is the state population from the 2000 U.S. Census.

*Sources*: NLN, AACN, State higher education coordinating boards.

## Enrollments and graduations in baccalaureate and master's level nursing programs increased slightly from 2001 to 2002.

Table II-e.

| PHARMACY EDUCATION | | | |
|---|---|---|---|
| # of Pharmacy Schools | **1** | Public Schools | **1** |
| | | Private Schools | **0** |
| # of Pharmacy Students, 2002-2003 | **222** | # Baccalaureate Degree | **12** |
| | | # Doctoral Degree *(PharmD)* | **210** |
| | # Per 100,000 population* | | **24.5** |
| # of Pharmacy Graduates, 2001-2002 | **65** | # Baccalaureate Degree | **21** |
| | | # Doctoral Degree *(PharmD)* | **44** |
| | # Per 100,000 population* | | **7.2** |

***** Denominator number is state population from 2000 U.S. Census.

*Source*: AACP.

**Table II-f.**

| PHYSICIAN ASSISTANT EDUCATION | | | |
|---|---|---|---|
| # of Physician Assistant Training Programs, 2002-2003 | **1** | Public Schools | **0** |
| | | Private Schools | **1** |
| # of Physician Assistant Program Students, 1997-1998[1,2] | | | **32** |
| # Physician Assistant Program Students per 100,000 Population, 1997-1998 | | | **3.53** |
| # of Physician Assistant Program Graduates, 2003 | | | **N/A** |
| # Physician Assistant Program Graduates per 100,000 Population, 2003 | | | **N/A** |

[1] Denominator number is state population from 2000 U.S. Census.

[2]There was no data available for the most recent years from Montana.

N/A= Data was not available

*Sources*: APAP, APAP Annual Report.

**Table II-g.**

| DENTAL EDUCATION | | | |
|---|---|---|---|
| # of Dental Schools | **0** | Public Schools | **0** |
| | | Private Schools | **0** |
| # of Dental Students, 2000-2001 | **0** | | |
| # Dental Students per 100,000 Population, 2000-2001* | **0** | | |
| # of Dental Graduates, 1999-2000 | **0** | | |
| # Dental Graduates per 100,000 Population, 2000* | **0** | | |
| State Appropriations to Dental Schools, 1997 | Per Student: **N/A*** | | |
| | As % of Total Revenue: **N/A*** | | |

***** Denominator number is state population from 2000 U.S. Census.

*Source*: ADA**.**

**Table II-h.**

| DENTAL HYGIENE EDUCATION | | | |
|---|---|---|---|
| # of Dental Hygiene Training Programs<br>The one school was newly opened in 2003. | **1** | Public Schools | **1** |
| | | Private Schools | **0** |
| # of Dental Hygiene Program Students, 2001-2002 | **0** | | |
| # Dental Hygiene Program Students per 100,000 Population* | **0** | | |
| # of Dental Hygiene Program Graduates, 2000-2001 | **0** | | |
| # Dental Hygiene Program Graduates per 100,000 Population* | **0** | | |

***** Denominator number is state population from 2000 U.S. Census.

*Sources*: ADHA, AMA Health Professions.

# III. PHYSICIAN PRACTICE LOCATION

The following tables examine in-state physician practice location from two different vantage points: (1) of all physicians who were trained (went to medical school or received their most recent GME training) in the state between 1975 and 1995, and (2) of all physicians who are now practicing in the state, regardless of where they were trained. Complied from the American Medical Association's 1999 Physician Masterfile by Quality Resource Systems, Inc., the data importantly illustrates to what extent physician graduates practice in many of the state's small towns, using the rural-urban continuum developed by the U.S. Department of Agriculture.

## PRACTICE LOCATION (URBAN/ RURAL) OF PHYSICIANS WHO RECEIVED THEIR MEDICAL SCHOOL TRAINING IN MONTANA BETWEEN 1975 AND 1995.

**Table III-a.**

| MONTANA | | |
|---|---|---|
| Number of physicians who were trained in MT and who are now practicing in MT **as a percentage of all physicians practicing in MT**. | | **0.00** |
| Number of physicians who were trained in MT and are practicing in MT, **by practice location** (metro code[1]), **as a percentage of all physicians practicing in MT**. | #00 | 0.00 |
| | #01 | 0.00 |
| | #02 | 0.00 |
| | #03 | 0.00 |
| | #04 | 0.00 |
| | #05 | 0.00 |
| | #06 | 0.00 |
| | #07 | 0.00 |
| | #08 | 0.00 |
| | #09 | 0.00 |
| Number of physicians who were trained in MT and who are now practicing in MT **as a percentage of all physicians who were trained in MT**. | | **0.00** |
| Number of physicians who were trained in MT and are practicing in MT, **by practice location** (metro code[1]), **as a percentage of all physicians trained in MT**. | #00 | 0.00 |
| | #01 | 0.00 |
| | #02 | 0.00 |
| | #03 | 0.00 |
| | #04 | 0.00 |
| | #05 | 0.00 |
| | #06 | 0.00 |
| | #07 | 0.00 |
| | #08 | 0.00 |
| | #09 | 0.00 |

[1] 1995 Rural/Urban Continuum Codes for Metro and Nonmetro Counties. Margaret A. Butler and Calvin L. Beale. Agriculture and Rural Economy Division, Economic Research Service, U.S. Department of Agriculture.

*Codes # 00-03 indicate metropolitan counties:*
00: Central counties of metro areas of 1 million or more
01: Fringe counties of metro areas of 1 million or more
02: Counties with metro areas of 250,000 - 1 million
03: Counties in metro areas of less than 250,000
*NA: Not Applicable; no counties in the state are in the R/U Continuum Code*
*Codes # 04-09 indicate non-metropolitan counties:*
04: Urban population of 20,000 or more, adjacent to metro area
05: Urban population of 20,000 or more, not adjacent to metro area
06: Urban population of 2,500-19,999, adjacent to metro area
07: Urban population of 2,500-19,999, not adjacent to metro area
08: Completely rural (no place w population > 2,500), adjacent to metro area
09: Completely rural (no place w population > 2,500), not adjacent to metro area

# PRACTICE LOCATION (URBAN/ RURAL) OF PHYSICIANS WHO RECEIVED THEIR MOST RECENT GME TRAINING IN MONTANA BETWEEN 1978 AND 1998.

**Table III-b.**

| MONTANA | | |
|---|---|---|
| Number of physicians who received their most recent GME training in MT and who are now practicing in MT **as a percentage of all physicians practicing in MT**. | | **0.00** |
| Number of physicians who received their most recent GME training in MT and are practicing in MT, **by practice location** (metro code[1]), **as a percentage of all physicians practicing in MT**. | #00 | 0.00 |
| | #01 | 0.00 |
| | #02 | 0.00 |
| | #03 | 0.00 |
| | #04 | 0.00 |
| | #05 | 0.00 |
| | #06 | 0.00 |
| | #07 | 0.00 |
| | #08 | 0.00 |
| | #09 | 0.00 |
| Number of physicians who received their most recent GME training in MT and who are now practicing in MT **as a percentage of all physicians who were trained in MT**. | | **0.00** |
| Number of physicians who received their most recent GME training in MT and are practicing in MT, **by practice location** (metro code[1]), **as a percentage of all physicians trained in MT**. | #00 | 0.00 |
| | #01 | 0.00 |
| | #02 | 0.00 |
| | #03 | 0.00 |
| | #04 | 0.00 |
| | #05 | 0.00 |
| | #06 | 0.00 |
| | #07 | 0.00 |
| | #08 | 0.00 |
| | #09 | 0.00 |

[1] 1995 Rural/Urban Continuum Codes for Metro and Nonmetro Counties. Margaret A. Butler and Calvin L. Beale. Agriculture and Rural Economy Division, Economic Research Service, U.S. Department of Agriculture.

*Codes # 00-03 indicate metropolitan counties:*

00: Central counties of metro areas of 1 million or more
01: Fringe counties of metro areas of 1 million or more
02: Counties with metro areas of 250,000 - 1 million
03: Counties in metro areas of less than 250,000

*Codes # 04-09 indicate non-metropolitan counties:*

04: Urban population of 20,000 or more, adjacent to metro area
05: Urban population of 20,000 or more, not adjacent to metro area
06: Urban population of 2,500-19,999, adjacent to metro area
07: Urban population of 2,500-19,999, not adjacent to metro area
08: Completely rural (no place w population > 2,500), adjacent to metro area
09: Completely rural (no place w population > 2,500), not adjacent to metro area

*NA: Not Applicable; no counties in the state are in the R/U Continuum Code.*

# IV. LICENSURE AND REGULATION OF PRACTICE

States are responsible for regulating the practice of health professions by licensing each provider, determining the scope of practice of each provider type and developing practice guidelines for each profession. The tables below illustrate the licensure requirements for each of the health professions covered in this study as well as additional information on recent expansions in scope of practice or other novel regulatory measures taken by the state.

**Table IV-a.**

| PHYSICIANS | |
|---|---|
| LICENSURE REQUIREMENTS | Degree in allopathic or osteopathic medicine. Completion of post graduate training. Score of 75 or more on National Board of Medical Examiners examination, Federation Licensing Examination (FLEX) or the USMLE. |
| LICENSURE REQUIREMENTS: *INTERSTATE TELE-CONSULTATION* | Must hold a telemedicine certificate from the state. The certificate allows an out-of-state physician to practice telemedicine, but does not allow the physician to practice while in the state. |
| STATE MANDATES INDIVIDUAL PROFESSION PROFILES TO BE PUBLICLY ACCESSIBLE | **No**. |

*Sources*: State licensing board, HPTS.

**Table IV-b.**

| PHYSICIAN ASSISTANTS | |
|---|---|
| LICENSURE REQUIREMENTS | Proof of graduation from an accredited physician assistant program. Proof of attaining a passing score on an examination given by the national commission of physician assistants. |
| RECENT STATE MANDATED EXPANSIONS IN SCOPE OF PRACTICE | ***PRESCRIPTIVE AUTHORITY***<br>Physician Assistants can prescribe schedule II-V medications and up to a 34 day supply of schedule II medications as delegated by a physician.<br><br>***PHYSICIAN SUPERVISION***<br>Communication between PA and physician by telephone, radio, or in person as frequently as the board decides is necessary. If practicing in a remote site, PA and supervising physician must work together in direct contact for a minimum of two weeks before PA delivers services in remote site. Supervising physician must visit remote site every 30 days or other interval. |

*Source*: State licensing board.

**Table IV-c.**

| NURSES | |
|---|---|
| LICENSURE REQUIREMENTS | **Registered Nurses (RNs):** Must have successfully completed at least an approved 4-year high school course of study or the equivalent as determined by the office of the superintendent of public instruction; have completed the basic professional curriculum in an approved school of nursing verified by official transcript; and passed the National Council of State Boards of Nursing (NCLEX) RN exam, or a Board approved licensing exam.<br><br>**Advanced Practice Nurses (APNs):** Must be licensed as an RN in Montana and have successfully completed a post basic professional nursing education program in the APRN area of specialty and received individual certification from a board approved certifying body or have a masters degree from an accredited nursing education program and have obtained national certification.<br><br>**Licensed Practical Nurses (LPNs):** Must have successfully completed at least an approved 4-year high school course of study or the equivalent as determined by the office of the superintendent of public instruction; have completed the basic professional curriculum in an approved school of nursing verified by official transcript; and passed the National Council of State Boards of Nursing (NCLEX) PN exam, or a Board approved licensing exam. |
| LICENSURE REQUIREMENTS: *FOREIGN-TRAINED NURSES* | Must pass the Montana licensing examination unless they have written a state board test pool licensing examination in another state of the United States. Candidates for licensure as registered nurses will be required to show evidence of having passed the commission on graduates of foreign nursing schools screening examination prior to writing the Montana licensing examination. Candidates for licensure as practical nurses will be required to show evidence of having successfully completed an English proficiency examination before admission to the Montana licensing examination |
| LICENSURE REQUIREMENTS: *INTERSTATE TELE-CONSULTATION* | **None.** State does not currently participate in interstate licensure compact developed by National Council of State Boards of Nursing. |
| RECENT STATE MANDATED EXPANSIONS IN SCOPE OF PRACTICE | *PRESCRIPTIVE AUTHORITY*<br>NPs and CRNAs can prescribe schedule II-V. No protocol required for prescribing. Schedule II limited to a 72-hour supply.<br><br>*PHYSICIAN SUPERVISION*<br>APNs practice in collaboration with a supervising physician. |
| RECENT STATE REQUIREMENTS TO IMPROVE WORKING CONDITIONS IN CERTAIN INSTITUTIONS | **None.** |
| STATE MANDATES INDIVIDUAL PROFESSION PROFILES TO BE PUBLICLY ACCESSIBLE | **No.** |

*Sources*: State licensing board, AANA, ACNM, Pearson "Annual Legislative Update", HPTS.

**Table IV-d.**

| DENTISTS | |
|---|---|
| LICENSURE REQUIREMENTS | Must have graduated from an accredited CODA (Commission on Dental Accreditation) approved dental school and have passed the National Board Part I and Part II and the Western Regional Examination (WREB), or Central Regional Dental Testing Service (CRDTS). |
| LICENSURE REQUIREMENTS: *INTERSTATE TELE-CONSULTATION* | **Full License.** |

*Source*: State licensing board.

**Table IV-e.**

| PHARMACISTS | |
|---|---|
| LICENSURE REQUIREMENTS | Must have a Bachelors Degree of Pharmacy from an ACPE (American Council of Pharmaceutical Education) accredited school of pharmacy, a minimum of 1500 internship hours, and must pass the NAPLEX with a 75% or better or pass the Multistate Pharmacy Jurisprudence Exam (MPJE) with a 75% or better. |
| RECENT STATE MANDATED EXPANSIONS IN SCOPE OF PRACTICE | State permits Collaborative Drug Therapy Management. |
| STATE MANDATES INDIVIDUAL PROFESSION PROFILES TO BE PUBLICLY ACCESSIBLE | **No.** |

*Source*: State licensing board.

**Table IV-f.**

| DENTAL HYGIENISTS | |
|---|---|
| LICENSURE REQUIREMENTS | Must have graduated from an accredited CODA (Commission on Dental Accreditation) approved dental hygiene school and passed the National Board Examination and the Western Regional Examination Board (WREB). |
| RECENT STATE MANDATED EXPANSIONS IN SCOPE OF PRACTICE | *PRESCRIPTIVE AUTHORITY*<br>None<br><br>*DENTIST SUPERVISION*<br>A licensed dental hygienist with a limited access permit may provide dental hygiene preventative services without dentist supervision in a public health setting. |

*Source*: State licensing board, ADHA.

## Glossary of Acronyms

CNM: Certified nurse midwife.

CRNA: Certified registered nurse anesthetist.

DEA: Drug Enforcement Agency.

HPSA: Health Professional Shortage Area

NCLEX: National Council Licensure Examination, administered by the National Council of State Boards of Nursing.

NP: Nurse practitioner.

RDHAP: Registered dental hygienist in alternative practice.

# V. IMPROVING THE PRACTICE ENVIRONMENT

States have the challenge of not only helping to create an adequate supply of health professionals in the state, but also ensuring that those health professionals are distributed evenly throughout the state. Various programs and incentives are used by states to encourage providers to practice in rural and other underserved areas. The tables in this section describe Montana's programs as well as the perceived effectiveness of these programs.

## RECRUITMENT/ RETENTION INITIATIVES

**Table V-a.**

| INITIATIVE | In Use | Perceived or Known Impact (1= high, 5= low) | Health Professions Affected | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | Physicians | Nurses | Pharmacists | Dentists | Dental Hygienists | Physician Assistants |
| FOCUSED ADMISSIONS / RECRUITMENT OF STUDENTS FROM RURAL OR UNDERSERVED AREAS | Yes | 2 | X | X | X | X | | |
| SUPPORT FOR HEALTH PROFESSIONS EDUCATION (stipends, preceptorships) IN UNDERSERVED AREAS | Yes | 2 | X | X | X | X | X | X |
| RECRUITMENT / PLACEMENT PROGRAMS FOR HEALTH PROFESSIONALS | Yes | 2 | X | X | X | X | X | X |
| PRACTICE DEVELOPMENT SUBSIDIES (i.e., start-up grants) | No | | | | | | | |
| MALPRACTICE PREMIUM SUBSIDIES | No | | | | | | | |
| TAX CREDITS FOR RURAL / UNDERSERVED AREA PRACTICE | Yes | 3 | X | | | | | |
| PROVIDING SUBSTITUTE PHYSICIANS (*locum tenens* support) | No | | | | | | | |
| MALPRACTICE IMMUNITY FOR PROVIDING VOLUNTARY OR FREE CARE | Yes | N/A | X | X | X | X | X | X |
| PAYMENT BONUSES / OTHER INCENTIVES BY MEDICAID OR OTHER INSURANCE CARRIERS | No | | | | | | | |
| MEDICAID REIMBURSEMENT OF TELEMEDICINE | Yes | 3 | X | | | | | |

*Source*: State health officials.

N/A = Data was not available.

**Montana uses malpractice immunity, placement programs and support for health professions education in underserved areas to recruit the major health professions.**

# LOAN REPAYMENT/ SCHOLARSHIP PROGRAMS *

**Table V-b.**

| Program Type | Number of Programs | Number of Annual Participants | Average Retention Rate | Eligible Health Professions | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Physicians | Nurses | Pharmacists | Dentists | Dental Hygienists | Physician Assistants |
| LOAN REPAYMENT | 2 | N/A | N/A | X | X | | | | |
| SCHOLARSHIP | 0 | 0 | N/A* | | | | | | |

* Includes only state-funded programs which require a service obligation in an underserved area. (NHSC state loan repayment programs are included since the state provides funding.)

N/A Data was not available

N/A* Data was not applicable

*Source*: State health officials.

# WORKFORCE PLANNING ACTIVITIES*

**Table V-c.**

| ACTIVITY | In Use | Health Professions Affected | | | | | |
|---|---|---|---|---|---|---|---|
| | | Physicians | Nurses | Pharmacists | Dentists | Dental Hygienists | Physician Assistants |
| COLLECTION / ANALYSIS OF PROFESSIONS SUPPLY DATA: FROM *PRIMARY* SOURCES (e.g., licensure renewal process; other survey research) | Yes | X | X | X | X | X | X |
| FROM *SECONDARY* SOURCES (e.g., state-based professional trade associations) | Yes | X | X | X | X | X | X |
| PRODUCTION OF RECENT STUDIES OR REPORTS THAT DOCUMENT / EVALUATE THE SUPPLY, DISTRIBUTION, EDUCATION OR REGULATION OF HEALTH PROFESSIONS | Yes | X | X | X | X | X | X |
| RECENT REGULATORY ACTIONS INTENDED TO REQUIRE OR ENCOURAGE COORDINATION OF POLICIES AND DATA COLLECTION AMONG HEALTH PROFESSIONS GROUPS OR LICENSING BOARDS | No | | | | | | |

* One state health official supplied these responses. Therefore, data may be limited and may not accurately reflect all current workforce-planning activities in the state.

**Montana collects supply data and produces studies and evaluations for all the major health professions.**

# VI. EXEMPLARY WORKFORCE LEGISLATION, PROGRAMS AND STUDIES

The following abstracts describe several of Montana's recent endeavors to understand and describe the status of the state's current health care workforce.

## Legislation and Programs

**H-65 (2003)**
This law makes revisions to the existing dentistry and dental hygiene laws. The act waives licensure rules to allow retired or non-practicing dentists and dental hygienists to apply for a license to practice dentistry or dental hygiene for indigent or uninsured patients in underserved or critical need areas. The law also exempts dental students, dental hygiene students, and dental residents who practice without pay under supervision from certain licensure requirements.

**H-494 (2003)**
This law revises the laws governing licensure of physicians and provides for temporary licensure of people in an approved residency program.

**S-363 (2003)**
This law places a limitation on awards for punitive damages of the lesser of either $10 million or three percent of a defendant's net worth.

**S-290 (2001)**
This law allows advance practice nurses to provide medical certification regarding cause of death on a death certificate.

**H-399 (2000)**
This law creates a telemedicine certificate for physicians practicing telemedicine in the state. It prohibits the practice of telemedicine in the state with such a certificate and defines and provides the requirements for obtaining a telemedicine certificate.

**Income Tax Credit, 1991**
Physicians serving in rural areas are eligible for a tax credit each year for up to four years that they practice in a qualifying area. The physician must practice in the area for at least nine months during the year for which they are claiming a credit.

**WWAMI Medical Education Program**
*Montana State University and University of Washington*
This program is a cooperative between the University of Washington and the states of Wyoming, Alaska, Montana, and Idaho. The program is designed to make medical education accessible to students in the region by sharing existing facilities and personal in the universities. Each year 20 Montana residents are admitted to the University of Washington School of Medicine as a part of the program. Students in the program are encouraged to choose careers in primary care practice and to locate their practices in non-metropolitan areas.

# Studies

**Competing for Quality Care**
*Blue Ribbon Task Force on Health Care Workforce Shortage's, September 2002*
The Governor convened a task force in October of 2001 to assess the shortage of health care workers in the state and to develop recommendations to address the issues related to workforce. The Task Force identified five major issue areas where improvements could be made to help Montana's workforce: 1) the state's health care climate; 2) educational opportunities; 3) the health care work environment; 4) reimbursement and compensation; and 5) health care workforce data collection and analysis. The report outlines the Task Force's findings in each of these areas and offers fourteen recommendations for improvements.

**Comparison of Montana Physician Fees with Other States**
*Consultec, March 2001*
This report provides an analysis of Montana's Medicaid fees in comparison to other states in a 2000 study by the Urban Institute. The study found that Montana's fees tended to be higher than the national average and had increased along with other states since 1993. The report found that while Montana was one of the higher paying states, which was true to a lesser extent than during the period on prior to 1993.

**Rural North Central Montana Partnership: Final Report**
*Montana State University, March 2002*
This is a collaborative project of nursing education programs in the state to address the short and long term nursing needs of rural Montana. Three nursing programs in the state came together to assess the health care environment in six rural counties in the state and to examine the interest of nurses to practice in those areas, the opportunities and resources available to nursing students, and the recruitment and retention initiatives efforts being made. The programs concluded that a shortage of registered nurses existed in North Central Montana and that the key factors in recruiting and retaining nurses in that area were adequate compensation and satisfying working conditions. Furthermore, the report found that there was interest from residents in the area to enroll in a nursing education program and that general education programs could be offered in the area via distance education.

**Montana Dental Work Force Analysis**
*WWAMI Center for Health Workforce Studies, May 2001*
This report details the results of a survey of dentists in the state on various topics related to access and the practice of dentistry in Montana. The survey included seven sections on demographics, dental education, practice characteristics, staff and recruitment, patient characteristics, and job satisfaction and was mailed to all licensed dentists in the state of which nearly ninety percent responded.

# VII. POLICY ANALYSIS

## Statewide Organizations with Significant Involvement in Health Workforce Development/Analysis

- **Montana Hospital Association**
- **Montana Area Health Education Center**
- **Montana Department of Public Health and Human Services**
  - **Primary Care Office**
- **Montana Family Practice Residency**
- **Montana State University**

**Evidence of Collaboration: Minimal (largely associated with profession recruitment and retention)**

Montana is very rural, largely frontier, state with a small minority population. The state's proportion of residents without health insurance is above the national average. This is partly attributable to Montana's predominant number of small business who say they cannot afford to offer such coverage to their employees. Of equal concern is the persistent lack of geographical access to health care professionals. The proportion of the state's population residing in primary care health professional shortage areas (HPSAs) exceed the national average; the percentage living in dental HPSAs is more than double the national proportion. Montana's overall per capita supply of physicians and nurses is also below national ratios. The state's number of pharmacists and dentists per capita mirrors or exceeds nationwide figures.

Efforts by the state to address health workforce shortages have been piecemeal. Montana enjoys having a ratio of National Health Service Corps (NHSC) professionals per HPSA population that is nearly four times the national ratio. State officials openly state that Montana relies heavily on the NHSC program to address its physician shortages. Although historically the state's Medicaid program is viewed as a better-than-average payer, provider reimbursement rates, particularly for physicians, were reduced for a couple of years to address state budget shortfalls. Less than a fifth of all participating physicians in Medicaid receive annual payments greater than $10,000, suggesting that Medicaid patients do not represent a significant proportion of practice income for these physicians. On the other hand, Medicaid payment rates for dentists in recent years have risen, and Medicaid payments to pharmacists remain attractive. In general, those providers that do the most to serve Medicaid recipients reportedly have no additional capacity to serve more Medicaid patients.

State officials rate many of the state programs intended to improve provider recruitment and retention in Montana is being particularly effective. The Montana Rural Physician Incentive Program, a loan repayment initiative created in 1991 to encourage primary care physicians to practice in rural medically underserved areas of the state, and the Montana Family Practice Residency, established in the late 1990s to accomplish a similar objective, are two programs viewed as being successful. Seen by state officials as somewhat effective is Montana's tax credit for health professionals practicing in rural areas of the state. Begun in 1991, the $5,000 state tax credit, originally only for physicians, is available to all health professionals practicing in the state's designated shortage areas.

With Montana lacking its own medical or dental school, the state has had a longstanding arrangement through the Western Interstate Commission for Higher Education (WICHE) and the Washington, Wyoming, Alaska, Montana and Idaho (WWAMI) Regional Medical Education Program to enroll qualified students in out-of-state medical and dental schools as well as other health professions training

programs in the region. Although there is no obligation for these students to return to practice in Montana, some data indicates that more than half of medical students return. In general, the WICHE arrangements are viewed as benefiting more the student than improving the state's health care workforce. Montana's AHEC and other state programs have had a longstanding involvement in encouraging the state's youth to enter health care careers.

In general, a comprehensive database of ongoing information on supply and demand of the state's health workforce is non-existent. The Montana Area Health Education Center (AHEC), Department of Public Health and Human Services' Primary Care Office, Montana Department of Commerce, and others routinely track certain supply trends associated with the state's health care workforce.

Growing concern with mounting shortages of health care workers prompted Montana's governor in 2001 to appoint a Blue Ribbon Task Force on Health Care Workforce Shortages to assess the extent of the problem and develop recommendations and strategies to effectively address the issue. A 2002 report offered various recommendations to improve educational opportunities, the health care work environment, worker reimbursement and compensation, and workforce data collection and analysis. Since the issuance of the report, there appears to be no comprehensive support to address the report's findings and recommendations. Despite some exceptions, there also has been little attention to and collaboration among educational institutions and others for improving the statewide number and capacity of health professions training programs in Montana.

**Medicine**

Montana's efforts to address the geographic maldistribution of the state's physician workforce by encouraging more graduating physicians to practice in shortage areas have been helpful. However, there has been an increase in the number of physicians who are older and foreign-trained. In relation, a large proportion of active physicians work under *locum tenens* arrangements and do not have a regular practice in one or more locations.

The state relies to a significant extent on physician assistants and nurse practitioners to deliver primary care in many locations unable to attract a physician. A significant proportion of physician assistants practice in rural settings under some level of remote physician supervision. Nurse practitioners are allowed to practice independent of a physician in Montana and about 80 percent of nurse practitioners choose to practice in this way.

**Nursing**

Although, data on the state's changing demand for and supply of nurses is lacking, there is a growing consensus that a growing nursing shortage in Montana, like elsewhere, is associated with an insufficient capacity of nurse training programs to educate more nurses. Despite increased enrollment in the state's five nurse training programs, increasing numbers of qualified applicants must be turned away. There is greater concern with reports that at least 60 percent of newly trained nurses in Montana leave the state upon graduation due to perceptions that Montana lacks attractive or fulfilling work environments for nurses burdened by loans and other issues. The state's annual number of newly licensed nurses is in decline. While recent data finds that Montana hospitals increasingly have problems filling vacant nurse positions in their institutions, nurse turnover rates are about three times vacancy rates on average.

To counter these trends, many hospitals and nursing schools offer loan repayment opportunities to nursing students. The Montana State University College of Nursing in partnership with other nurse training

programs in the state has agreed to expand nursing education opportunities in rural areas by offering on-site courses in nursing and other health science programs more attractive and available to students in rural settings.

**Dentistry**

Montana has no dental school and just one dental hygiene training program which recently opened. According to a 2003 survey of the state's dentists, the dentist population in Montana, like elsewhere, is rapidly aging, and there are growing concerns that their supply are not being adequately replenished. The dentist shortage is seen becoming acute in rural areas of eastern Montana. Montana, like a growing number of other states, has recently adopted 'licensing by credential' as one way of more effectively increasing the supply of dentists, particularly in rural areas.

The fledgling supply of dentists appears to operating at capacity and unable to see new patients. Close to 80 percent are enrolled in Medicaid, but less than a third of those receive annual Medicaid payments greater than $10,000, suggesting that Medicaid patients do not represent a significant proportion of practice income for most dentists.

The new dental hygiene program, which in essence replaced the state's one school that closed in 1989, is challenged to address the current demand by dentists for hygienists. Many hygienists are recruited to dentist practices from outside Montana. In general, hygienists in Montana have relatively liberal supervision arrangements with dentists.

**Pharmacists**

Like other states, Montana's one school of pharmacy is rapidly moving to graduating all doctoral degree level students of pharmacy. Reports suggest that about 60 percent of the school's graduates remain in the state to practice. A significant number of practicing pharmacists in the state are older and come from outside Montana.

Montana does not yet appear to have a significant problem with overall pharmacist supply. The supply of pharmacists in the state is above the national average. The state's hospitals and drug stores, particularly in rural communities, reportedly are having significant recruiting difficulties.

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